Thames Williams Care

Everley Residential Home

Inspection report

15 Lyde Green
Halesowen
West Midlands
B63 2PQ

Tel: 01384566686

Date of inspection visit:
22 September 2020
24 September 2020
25 September 2020
28 September 2020

Date of publication:
11 January 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Everley Residential Home is a residential care home providing personal care and accommodation to people aged 65 and over who may also be living with dementia or physical disabilities. The care home is registered to provide support to 16 people in one adapted building, at the time of inspection 10 people lived at the home.

People's experience of using this service and what we found
Care and treatment was not provided in a safe way. People were at risk of dehydration and this had not been addressed by the registered manager or provider. People had lost weight, and this had not been escalated to relevant professionals.

People were not protected from potential harm and abuse. People had been subject to abuse and this had not been escalated and investigated to prevent further occurrences. Abuse or improper treatment was not always reported, investigated or acted on.

The provider's systems failed to identify that care and treatment was not provided in a safe way. Audits did not identify risks to people, safeguarding concerns and a failure to report incidents. Staff practice was not effectively monitored.

An infection prevention control audit was carried out by CQC during the inspection. It was found the provider was not meeting government guidelines in regard to COVID-19. People had not been isolated in the home on return from hospital increasing the risks of potential COVID-19 spread. Staff and people had not received regular COVID-19 tests.

Relatives had not been informed when things had gone wrong or their loved ones had been subject to harm or abuse. The provider and registered manager failed to act in an open and transparent way when things went wrong.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (06 August 2020). The service remains rated inadequate. This service has been rated inadequate for the last two consecutive inspections. The provider was asked to complete an action plan after the last inspection to show what they would do and by when to improve, but they failed to submit this. At this inspection improvement had not been made and the provider was still in breach of regulations.

This service has been in Special Measures since 06 August 2020. During this inspection the provider was not able to demonstrate that improvements have been made. The service remains in Special Measures.

Why we inspected
We received concerns in relation to the overall management of the home, people's health needs and people's weights. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained as inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Everley Residential Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, safeguarding, governance, the registered managers ability to carry out the regulated activity, infection control and the environment, a failure to notify and a failure in duty of candour at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Everley Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors. Two inspectors visited the home and one inspector reviewed evidence and made phone calls offsite.

Service and service type
Everley Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information we had received about the service since

the last inspection. We received feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with three relatives about their experience of the care provided. We spoke with the provider, registered manager and two staff. We reviewed a range of records. This included three people's care records and multiple medication records. We looked at one staff file in relation to recruitment and staff supervision. A variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at numerous different documents. However, some evidence we requested was not provided. We spoke with external professionals and the local authority to ensure people were safe.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection the provider and registered manager had failed to ensure people were safeguarded from abuse. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Insufficient improvements had been made in regard to safeguarding people at the inspection. Therefore, the provider was still in breach of regulation 13.

• During the last inspection systems and processes were not established and operated effectively to prevent abuse of people living at the home. During this inspection we found significant concerns about the registered manager and the provider's ability to safeguard people.
• Over two months, eight incidents occurred where people were subjected to verbal or physical aggression. These had not been raised to the local authority safeguarding team or CQC. This placed people at significant risk of abuse.
• Over the same two months, 10 incidents occurred where threats of violence were made towards staff. A further six incidents were recorded of attempted or actual physically assault on staff. The provider and registered manager told us they were aware of all the incidents and made referrals to community teams for support. However, they had not considered the risk to people living in the home. Nothing was put in place to reduce the risk whilst awaiting input from external teams. This placed people at risk of abuse.
• The registered manager and provider did not recognise the impact of verbal abuse and physical threats on people living at the home. A staff member said, "Some people are scared of [person] and get upset. [Person] and [person] get affected. We have raised the worry [with registered manager] but it's not been dealt with." This meant people were subject to verbal abuse and physical threats and appropriate action was not taken to effectively reduce risk.
• A relative told us their loved one had been subject to abuse in the home, they said, "It does make me feel quite sick to think my [relative] was in there on their own and the people who were supposed to be acting as a guardian weren't doing their jobs. The emotional impact it had on myself and family has been really quite devastating."
• The provider had made the decision to reduce staffing levels in the home meaning there were times when people were left unsupported in communal areas. This decision was made based on the number of people living in the home and not on their support needs or risks they posed. This placed people at significant risk of harm and abuse. A staff member said, "Staff levels reduced down to two when we couldn't have new people in, due to Covid. It's not safe [with two staff]."

A failure to ensure people were safeguarded from risk was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

At our last inspection the provider and registered manager had failed to ensure care and treatment was provided in a safe way. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvements had not been made in regard to safety. Therefore, the provider was still in breach of regulation 12.

• During the last inspection the provider and registered manager failed to mitigate known risks to people. This meant they failed to ensure care and treatment was being provided in a safe. This placed people at risk of poor and unsafe care. During this inspection we found significant concerns in regard to people's safety. A relative told us, "I'm not 100% convinced [relative] is properly looked after no… [staff] don't know if health issues are resolved or not. I'm not convinced [relatives] care is good."
• Over an 11-week period, concerns were recorded on 18 separate occasions for one person related to signs of a possible infection. There were a further nine separate recordings on different dates indicating the person was unwell. No action was taken by the registered manager or provider to report any of these concerns to appropriate medical professionals therefore the person did not receive any medical treatment. At the time of inspection, a safeguarding investigation was taking place to identify what impact this had on the person.
• Care plans and risk assessments did not contain sufficient guidance for staff to keep people safe. One person's catheter care plan did not identify signs for staff to look out for to indicate they may be experiencing problems or possible infections. On some occasions staff had recorded concerns in relation to the person's catheter, but this was not consistently recorded. This put people at risk of harm.
• There was insufficient recording and monitoring of people's fluid intake. Fluid intake charts had no total at the end of each day, so it was not clear if people had received enough fluid. One person had not met their fluid goal on 31 days. Another person had no fluid goal but had been identified as a risk of dehydration. On 28 occasions the person had consumed less than a litre of fluid, and one day had no fluid consummation was recorded at all. The registered manager did not act to address the lack of fluid intake placing people at risk of dehydration.
• People were weighed on a regular basis. Records showed two people had been losing weight over an eight-month period. No action was taken to contact medical professionals or seek medical advice to ascertain what was causing the weight loss or what could be put in place to address this. A staff member said, "I have raised to [registered manager and provider] about it [weight loss]. We would document in daily notes, but nothing really got done." This placed people at risk of harm.
• Over three weeks, there had been three occasions where a person had choked whilst drinking. The registered manager said they had made a referral to speech and language therapy (SALT). The local authority safeguarding team investigated this concern and found the SALT team had not received a referral. The registered manager was unable to provide evidence a referral had been made. There was no mention of the risk in relation to choking in the person's care plans. A choking risk assessment was in place but was dated seven months after the initial choking incident occurred. This placed the person at significant risk of harm.

A failure to ensure care and treatment is provided in a safe way was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection the provider had failed to ensure the premises and equipment was maintained to appropriate standards of hygiene. This placed people at risk of infection and environmental health issues. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvements had not been made in regard to infection control practices at the inspection. Therefore, the provider is still in breach of regulation 15.

• During the last two inspections, the utility room was used for washing and drying clothes but also for cleaning toileting equipment. The staff had told us they could not prevent splashes from the sink coming into contact with clean laundry. During this inspection no changes had been made to the laundry room. The provider had a plan for building a new washing facility, but no changes had been made to prevent cross contamination. This meant there was a risk of cross contamination.

A failure to ensure a safe environment was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• An infection prevention control audit was carried out by CQC during the day of inspection. It was found the provider was not meeting government guidelines in regard to COVID-19. For example, they had not safely admitted people into the service following a hospital stay and staff and people had not received regular COVID-19 tests. We have signposted the provider to resources to develop their approach.
• One person had been in hospital and on return to the home had not been isolated. No consideration as to how to maintain social distancing had been given and no risk assessment was in place for the risks associated with COVID-19. This placed people at risk of contracting COVID-19.
• The registered manager was not consistently wearing a mask in line with guidance. In addition, people and staff had not received regular COVID-19 tests.

A failure to ensure care and treatment is provided in a safe way was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• During the last inspection there had been two occasions where medicine stocks did not balance. During this inspection there were four occasions where medicine stocks did not balance with what should have been in stock. We did not find that anyone had been harmed because of this and the provider investigated and said it was a recording error.
• Staff had received medicines training and competency assessments. However, staff had also received training on how to record on medicines administration records, but the errors mentioned above had occurred when records had been completed.

Staffing and recruitment
• Staff had been recruited safely. Pre-employment checks had been carried out to ensure staff were suitable for the role.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider's systems and processes were not robust enough to demonstrate the service was operating effectively. This placed people at risk of potential harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider is still in breach of regulation 17.

• During the last inspection the provider and registered manager had not assessed the risks relating to health, safety and welfare of the people living in the home. The registered manager and provider said they were going to review people's care plans and risk assessments. However, we found the same concerns at this inspection, therefore people continued to be exposed to risk.
• A relative said, "I just think you give your loved one over to the care of others with the best intentions and I feel really badly betrayed by the care home and the manager."
• During the last inspection we identified shortfalls in the provider and registered managers audit systems and processes. We found the same concerns at this inspection. For example, audits of incident forms had not identified safeguarding concerns that should have been notified to the local authority and CQC. In addition, medicines audits did not identify issues we found. Therefore, people continue to be exposed to the risk of immediate and ongoing harm.
• Systems and processed in place to monitor the service were inadequate. For example, During the last inspection systems to monitor staff practice did not identify staff were not complying with government guidance in relation to PPE. We found continued concerns with regard to government guidelines for COVID-19 not being adhered to. Systems in place to ensure people's health needs were being met, as detailed in the safe domain, failed. Therefore, people did not receive medical attention in a timely manner exposing them to risk of harm.
• There were delays in information being sent to the inspector, by the registered manager and provider, following the inspection. Numerous telephone calls and emails had to be sent, some information requested was received after the deadlines specified and some information was not received. This meant there were delays in collating and corroborating evidence.

The lack of robust quality assurance meant people were at risk of receiving poor quality care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the incidents that had occurred in the service had not been notified to CQC in line with legal requirements. This was a breach of Regulation 18 (Notification of other incidents) of Care Quality Commission (Registration) Regulations 2009.

Enough improvement had not been made at this inspection and the provider is still in breach of regulation 18.

• The registered manager and provider had not notified CQC of all events which had occurred within the service in line with legal requirements. The provider was in the process of reviewing incidents and notifying CQC in retrospect.

Not notifying the Care Quality Commission of events that have occurred in the service in line with legal requirements, is a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18.

Continuous learning and improving care

At our last inspection the registered manager lacked the skills, competence and knowledge to manage the carrying out of the regulated activities. This was a breach of regulation 7 (Requirements relating to registered manages) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider is still in breach of regulation 7.

• During the last inspection serious concerns about people's safety were identified and the registered manager said they were not aware of them. However, a safeguarding investigation found the registered manager had been told about peoples known risks. During this inspection we identified serious concerns about people's safety, the registered manager was aware of these concerns and failed to act. This meant the registered manager failed to act on known risks to keep people safe.
• During the last inspection staff told us they had raised concerns to the registered manager, and these had not been dealt with. During this inspection we found conflicting opinions from staff as to whether safeguarding issues wold be dealt with.
• One staff member said they felt issues would be dealt with and they didn't have any concerns. One staff member told us they had raised concerns about incidents of abuse, as detailed in the safe domain, and they had not been acted on. We received anonymous whistleblowing concerns from a staff member saying the manager had been made aware of safeguarding concerns by staff and hadn't dealt with them. This meant the registered manager continued to fail to act on concerns raised by staff putting people at increased risk of harm and abuse.

The registered manager lacked the skills, competence and knowledge to manage the carrying out of the regulated activities. This was a breach of regulation 7 (Requirements relating to registered manager) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The provider and registered manager failed to act in an open and transparent way when things went

wrong.
• Systems and processes failed to identify duty of candour had not been adhered to. Duty of candour means every healthcare professional must be open and honest with people when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.
• Families of people living at Everley Residential Home had not been informed when their loved ones had been placed at risk or come to harm. This meant families were not able to offer their loved one's emotional support.
• A relative told us, "After the inspection [in June] they [manager and provider] might have had the courtesy to ring us and let us know what's going on rather than let us find out by pure chance. We always watch the news, or we wouldn't have found out."
• Families told us they had not been informed of the concerns raised as part of the last inspection and had found out via the news or media outlets. One family told us they had asked the registered manager what had gone wrong after seeing a new report, they felt they had been misled by the registered manager as to what the concerns were.

The failure to be open and transparent was a breach of regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• The provider and registered manager had received regular input from external professionals to support them with improvement and development of the home. There was a lack of evidence to suggest they had taken on board advice and guidance and made and sustained improvement.
• People did not receive person centred care and did not always have positive outcomes. One relative told us, "My relative shares a room, when [the person they shared with] died there were no covers around the bed, so they saw everything. They shouldn't see that kind of thing."
• Relatives told us they had very limited or no contact with their loved ones during the pandemic and the home had made no effort to contact them. Comments from relatives included, "I haven't been there for eight months and not been able to speak to [person] on the telephone. I've not seen [person] at all" and, "No updates given to us. Only time we have got to find anything out is when we phone them. [The home] call us when they need toiletries. We have accepted it as we thought it was part of the course due to lock down and Covid."

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment A failure to ensure care and treatment is provided in a safe way was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a notice of decision to cancel the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment A failure to ensure people were safeguarded from risk was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a notice of decision to cancel the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment A failure to ensure a safe environment was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a notice of decision to cancel the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of robust quality assurance meant people

were at risk of receiving poor quality care. This was a
breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities)
Regulations 2014.

The enforcement action we took:

We served a notice of decision to cancel the providers registration